# Application for License to Operate a Long-term Care Facility

For Office Use Only
Received: 2/4/11
Amount: 155.00
# 79504



## I. IDENTIFICATION

| | |
|---|---|
| Name | King's Daughters Medical Center |
| Address | 2201 Lexington Avenue |
| City/County/Zip | Ashland, Boyd, 41101 |
| Telephone number | 606-327-4000 |
| Administrator | Danny Joe Brainard, Jr. |
| Date facility operation began at current address | 1985 |
| Date facility began operation under current owner | 1985 |

## II TYPE BEDS

| | No. beds licensed | No. beds requested |
|---|---|---|
| Skilled | 0 | 0 |
| Nursing Home | 0 | 0 |
| Nursing Facility | 10 | 10 |
| Intermediate Care | 0 | 0 |
| ICF/MR | 0 | 0 |
| Personal Care | 0 | 0 |

## II CONTROL (Check one in each column)

State
County
City
(Private)

Profit
(Non Profit)



Individual
Partnership
(Corporation)

## II. OWNERSHIP

Name and address of individual owner, partner or corporation. If partnership, list partners.

Ashland Hospital Corporation

(OVER)

2/28

If facility is owned by a corporation, complete the following:

| | |
|---|---|
| Name of corporation | Ashland Hospital Corporation |
| Address of corporation | 2201 Lexington Avenue Ashland Kentucky 41101 |
| President or Chairman | David Jones |
| Vice President | Ray Mecca, MD |
| Secretary | Sheryl Mahaney |
| Treasurer | Paul McDowell |

Attach a separate sheet listing the names and addresses of each person having at least twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. (see attached list)

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

| Parent | Management Company |
|---|---|
| Ashland Hospital Corporation | |
| 2201 Lexington Avenue | |
| Ashland, Kentucky 41101 | |

I understand that any change in the application that affects my licensure status will be reported to the Division of Community Health Services and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Danny Joe Brainard, Jr. — Signature of Authorized Representative

Administrator — Title

1/27/11 — Date

Return Application and Fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)